

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0035253</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>South Haven Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/01</u> to <u>09/30/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>500 S. Red</u> <u>Robinson</u> <u>62454</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Crawford</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>( 618 ) 346-1204</u> <b>Fax #</b> <u>( 217 ) 398-0944</u>		(Type or Print Name) <u>Dennis Carpenter</u>	
<b>IDPA ID Number:</b> <u>37-1225266003</u>		(Title) <u>Chief Financial Officer</u>	
<b>Date of Initial License for Current Owners:</b> <u>01/25/89</u>		(Signed) <u>See Attached Compilation Report</u> (Date) _____	
<b>Type of Ownership:</b>		<b>Paid Preparer</b> (Print Name and Title) <u>David W. Hood, CPA</u> <u>Member</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		(Firm Name & Address) <u>Martin, Hood, Friese, &amp; Associates, LLC</u> <u>2507 S. Neil Street, Champaign, IL 61820</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>( 217 ) 351-2000</u> <b>Fax #</b> <u>(217) 351-7726</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Dennis Carpenter</u> <b>Telephone Number:</b> <u>( 217 ) 398-0754</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number South Haven Home# 0035253 Report Period Beginning: 10/1/01 Ending: 09/30/02

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>4,706</u>			<u>4,706</u>	13
14	TOTALS	<u>4,706</u>			<u>4,706</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 80.58%

D. How many bed-hold days during this year were paid by Public Aid?

160 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/11/89

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 1/11/89 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/02 Fiscal Year: 09/30/02

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

South Haven Home

# 0035253

Report Period Beginning:

10/1/01

Ending:

09/30/02

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	24,698	10	1,962	26,670		26,670	2,023	28,693		1
2	Food Purchase		25,085		25,085		25,085	757	25,842		2
3	Housekeeping	22,844	5,663		28,507		28,507	55	28,562		3
4	Laundry	14,065	102		14,167		14,167		14,167		4
5	Heat and Other Utilities			11,854	11,854		11,854	1,012	12,866		5
6	Maintenance	5,909		21,838	27,747		27,747	4,021	31,768		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	67,516	30,860	35,654	134,030		134,030	7,868	141,898		8
	<b>B. Health Care and Programs</b>										
9	Medical Director		3,245	2,100	5,345		5,345	185	5,530		9
10	Nursing and Medical Records	75,003		83,855	158,858		158,858	(13,417)	145,441		10
10a	Therapy										10a
11	Activities	2,813	662		3,475		3,475	228	3,703		11
12	Social Services			3,850	3,850		3,850	(918)	2,932		12
13	Nurse Aide Training	12,182			12,182		12,182		12,182		13
14	Program Transportation			2,521	2,521		2,521	737	3,258		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	89,998	3,907	92,326	186,231		186,231	(13,185)	173,046		16
	<b>C. General Administration</b>										
17	Administrative			53,040	53,040		53,040	(16,141)	36,899		17
18	Directors Fees							166	166		18
19	Professional Services			11,203	11,203		11,203	(5,426)	5,777		19
20	Dues, Fees, Subscriptions & Promotions			1,741	1,741		1,741	1,323	3,064		20
21	Clerical & General Office Expenses	15,970	2,687	15,606	34,263		34,263	2,674	36,937		21
22	Employee Benefits & Payroll Taxes			31,157	31,157		31,157	25,285	56,442		22
23	Inservice Training & Education			375	375		375	1,293	1,668		23
24	Travel and Seminar							2,408	2,408		24
25	Other Admin. Staff Transportation			1,081	1,081		1,081	703	1,784		25
26	Insurance-Prop.Liab.Malpractice			1,771	1,771		1,771	1,407	3,178		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	15,970	2,687	115,974	134,631		134,631	13,692	148,323		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	173,484	37,454	243,954	454,892		454,892	8,375	463,267		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

South Haven Home

#0035253

Report Period Beginning:

10/1/01

Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			7,583	7,583		7,583	8,317	15,900			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3	3		3	2,399	2,402			32
33	Real Estate Taxes			6,072	6,072		6,072	231	6,303			33
34	Rent-Facility & Grounds			45,900	45,900		45,900		45,900			34
35	Rent-Equipment & Vehicles			3,330	3,330		3,330	663	3,993			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			62,888	62,888		62,888	11,610	74,498			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,781	25,781		25,781		25,781			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			25,781	25,781		25,781		25,781			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	173,484	37,454	332,623	543,561		543,561	19,985	563,546			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number South Haven Home

# 0035253

Report Period Beginning: 10/1/01

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## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule Sch. VIII	19,985		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 19,985		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 19,985		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

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ID# 0035253

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

09/30/02

[illegible]

## Summary B

09/30/02

## 09/30/02

[illegible]

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule VII C.		See Attached Schedule		Health Services Cons.	Champaign, IL	Consulting
				Cobblestone Rehab.	Champaign, IL	Therapy
				Specialized Developme	Champaign, IL	Long Term Care
				Developmental Found	Champaign, IL	Long Term Care
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals	Champaign, IL	Rental Real Estate

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V		See Schedule VII	\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number      South Haven Home      #      0035253      Report Period Beginning:      10/1/01      Ending:      09/30/02

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Alan Ryle	President	Administrative	0.50	All related party wages are allocations			Administrative	\$ 2,675	17-7	1
2	Alan Ryle	President	Administrative	0.50	from HSC. See attached allocation			Directors Fees	83	18-7	2
3	Lynn Ryle	Vice President	Administrative	0.50	spreadsheet and explanation. These			Administrative	2,185	17-7	3
4	Lynn Ryle	Vice President	Administrative	0.50	individuals receive no compensation from			Directors Fees	83	18-7	4
5					entities other than HSC.						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 5,026		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home# 0035253

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## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Office Management - division of TRD, Inc  
 Street Address P.O. Box 1044  
 City / State / Zip Code Champaign, IL 61824  
 Phone Number ( 217) 398-0754  
 Fax Number ( 217) 398-0944

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3	Office Management central office charges now included in HSC allocation on pages 8A and 8B.								3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home# 0035253

Report Period Beginning:

10/1/01Ending: 09/30/02

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Health Services Consultants, Inc.Street Address P.O. Box 1044City / State / Zip Code Champaign, IL 61824Phone Number (217) 398-0754Fax Number (217) 398-0944

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10	Nursing	Reverse expenses for actual amounts paid and accrued to		\$	\$		(76,496)	1	
2	6	Maintenance	HSC for services provided in order to allocate HSC's					(2,990)	2	
3	12	Social	actual expenses.					(4,200)	3	
4	17	Administrative						(53,039)	4	
5	21	Clerical						(10,800)	5	
6	24	Travel & Seminar						(166)	6	
7	14	Program Transportation							7	
8	19	Professional Services						(9,407)	8	
9	1	Dietary						(260)	9	
10									10	
11	1	Dietary	Revenue	6,157,136	13	30,047	30,047	157,358	2,269	11
12	2	Food Purchases	Revenue	6,157,136	13	1,817		157,358	46	12
13	3	Housekeeping	Revenue	6,157,136	13	1,630		157,358	42	13
14	5	Heat & Utilities	Revenue	6,157,136	13	39,582		157,358	1,012	14
15	6	Maintenance	Revenue	6,157,136	13	215,019	147,448	157,358	6,895	15
16	9	Medical Director	Revenue	6,157,136	13	1,655		157,358	42	16
17	10	Nursing	Revenue	6,157,136	13	2,124,819	2,099,008	157,358	63,153	17
18	11	Activities	Revenue	6,157,136	13	8,920		157,358	228	18
19	12	Social	Revenue	6,157,136	13	302,992	289,947	157,358	3,281	19
20	13	Nurse Training	Revenue	6,157,136	13			157,358		20
21	17	Administrative	Revenue	6,157,136	13	1,299,710	1,299,710	157,358	36,735	21
22	18	Director's Fees	Revenue	6,157,136	13	6,500		157,358	166	22
23	19	Professional Services	Revenue	6,157,136	13	68,714		157,358	1,756	23
24	20	Adv. Dues & Subscriptions	Revenue	6,157,136	13	39,037		157,358	998	24
25	TOTALS				\$ 4,140,442	\$ 3,866,160		\$ (40,735)	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home# 0035253

Report Period Beginning:

10/1/01Ending: 09/30/02

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Health Services Consultants, Inc.Street Address P.O. Box 1044City / State / Zip Code Champaign, IL 61824Phone Number ( 217 ) 398-0754Fax Number ( 217 ) 398-0944

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2	21 Clerical	Revenue	6,157,136	13	461,302	295,188	157,358	11,790	2
3	22 P/R Taxes & Benefits	Revenue	6,157,136	13	896,956		157,358	25,253	3
4	23 Inservice	Revenue	6,157,136	13	43,569		157,358	1,113	4
5	14 Program Transportation	Revenue	6,157,136	13	27,511		157,358	703	5
6	25 Administrative Transportation	Revenue	6,157,136	13	27,511		157,358	703	6
7	26 Insurance	Revenue	6,157,136	13	51,203		157,358	1,309	7
8	30 Depreciation	Revenue	6,157,136	13	311,566		157,358	7,963	8
9	32 Interest	Revenue	6,157,136	13	60,387		157,358	1,543	9
10	34 Building Lease	Revenue	6,157,136	13			157,358		10
11	35 Equipment Lease	Revenue	6,157,136	13	27,739		157,358	709	11
12	24 Travel & Seminar	Revenue	6,157,136	13	100,630		157,358	2,572	12
13	33 Real Estate Tax	Revenue	6,157,136	13	6,455		157,358	165	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,155,271	\$ 4,161,348		\$ 13,088	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home# 0035253

Report Period Beginning:

10/1/01Ending: 09/30/02

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization The Residential Developers, Inc.Street Address P.O. Box 1044City / State / Zip Code Champaign, IL 61824Phone Number (217) 398-0754Fax Number (217) 398-0944

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Days	5,110	7	\$ 4,961	\$ 365	\$ 354	1
2	10	Nursing & Med Rec.	Days	5,110	7	(968)	(968)	(69)	2
3	1	Dietary	Days	5,110	7	202	365	14	3
4	3	Housekeeping	Days	5,110	7	178	365	13	4
5	6	Maintenance	Days	5,110	7	1,622	365	116	5
6	14	Program Transportation	Days	5,110	7	478	365	34	6
7	9	Medical Director	Days	5,110	7	1,996	365	143	7
8	10	Nursing & Med Rec.	Days	5,110	7	(65)	365	(5)	8
9	19	Professional Services	Days	5,110	7	31,147	365	2,225	9
10	20	Fee, Subs & Promos	Days	5,110	7	4,544	365	325	10
11	21	Clerical & Gen Office	Days	5,110	7	23,574	365	1,684	11
12	22	Employee Ben. & P/R Tax	Days	5,110	7	446	365	32	12
13	23	Inservice Training & Educ	Days	5,110	7	2,523	365	180	13
14	24	Travel & Seminars	Days	5,110	7	25	365	2	14
15	26	Insurance	Days	5,110	7	1,377	365	98	15
16	12	Social Services	Days	5,110	7	18	365	1	16
17	17	Administrative	Days	5,110	7	2,277	365	163	17
18	32	Interest	Days	5,110	7	11,977	365	856	18
19	33	Real Estate Taxes	Days	5,110	7	917	365	66	19
20	35	Veh. & Equip. Lease	Days	5,110	7	(643)	365	(46)	20
21	2	Food	Days	5,110	7	9,959	365	711	21
22									22
23									23
24									24
25	TOTALS					\$ 96,545	\$	\$ 6,897	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC		X	Vehicle	\$870.00	12/12/01	\$ 31,316	\$ 23,487	12/26/04	zero	\$ Incl. in p.8C	1	
2	Schedule VIII Allocations		X								2,399	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Busey Bank		X	Working Capital	N/A	N/A	N/A	N/A			3	6	
7												7	
8												8	
9	TOTAL Facility Related				\$870.00		\$ 31,316	\$ 23,487			\$ 2,402	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 31,316	\$ 23,487			\$ 2,402	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME South Haven Home COUNTY Crawford  
FACILITY IDPH LICENSE NUMBER 0035253  
CONTACT PERSON REGARDING THIS REPORT Dennis Carpenter  
TELEPHONE ( 217 ) 398-0754 FAX #: ( 217 ) 398-0944

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

## B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 4,800

B. General Construction Type:
 Exterior
 Aluminim Siding
 Frame
 Wood
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Leasehold Improvements		1994		1,721	44	39	44		395	9
10	Leasehold Improvements		1995		8,178	303	27	303		2,102	10
11	Furniture		1998		1,214	45	27	45		209	11
12	Bathroom Repairs		1999		966	36	27	36		117	12
13	Protective Wall Covering		2000		560	21	27	21		43	13
14	Protective Wall Covering		2000		1,230	46	27	46		89	14
15	Ruud Furnance		2002		2,063	83	15	83		83	15
16	3 Ton A/C Unit		2002		1,400	47	10	47		47	16
17	Dishwasher		2002		644	32	5	32		32	17
18	Carpet		2002		7,266	242	5	242		242	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 25,242	\$ 898		\$ 898	\$	\$ 3,358	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 10,354	\$ 1,566	\$ 1,566		5/7	\$ 6,459	71
72	Current Year Purchases	2,505	159	159		7	159	72
73	Fully Depreciated Assets	2,405				5/7	2,405	73
74								74
75	TOTALS	\$ 15,264	\$ 1,725	\$ 1,725	\$		\$ 9,023	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Handicapped Van Conv.	1999	\$ 510	\$ 102	\$ 102		5	\$ 336	76
77	Patient Transportation	2001 Savana	2002	29,149	4,858	4,858		5	4,858	77
78										78
79										79
80	TOTALS			\$ 29,659	\$ 4,960	\$ 4,960	\$		\$ 5,194	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 70,165	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,583	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 7,583	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 17,575	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Milestone Midwest, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1988</u>	<u>15</u>	<u>1/11/89</u>	\$ <u>45,900</u>	<u>15</u>	<u>15</u>	3
4	Additions	<u>1991</u>	<u>1</u>					4
5								5
6								6
7	TOTAL		<u>16</u>		\$ <u>45,900</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

None

N/A

9. Option to Buy: ☐ YES ☒ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 3,330

Description: Fax & Copier Lease

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 1/11/89

Ending 1/10/04

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 09/30/2003 \$ 45,900

13. 09/30/2004 \$ 11,475

14. \_\_\_\_\_ \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE <u>40</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE <u>80</u>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	360	3,701		4,061
4	Clinical Wages (b)	720	7,401		8,121
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 1,080	\$ 11,102	\$	\$ 12,182
10	SUM OF line 9, col. 1 and 2 (e)	\$ 12,182			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	19

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist		hrs	\$	
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	100,080		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 100,080	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	25,242		15
16	Equipment, at Historical Cost	44,923		16
17	Accumulated Depreciation (book methods)	(17,575)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 52,590	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 152,670	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,178		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,537		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 14,715	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	23,487		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 23,487	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 38,202	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 114,468	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 152,670	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 188,080</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 188,080</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(95,230)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (95,230)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Transfers (to) from The Residential Developers, Inc.</b>	<b>21,618</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$ 21,618</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 114,468</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 448,331	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 448,331	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 448,331	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	134,030	31
32	Health Care	186,231	32
33	General Administration	134,631	33
	<b>B. Capital Expense</b>		
34	Ownership	62,888	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	25,781	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 543,561	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(95,230)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (95,230)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax return is on a 12/31 fiscal year and is on the cash basis.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number South Haven Home# 0035253Report Period Beginning: 10/1/01Ending: 09/30/02

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	1,580	1,580	12,182	7.71	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	365	365	2,813	7.71	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,613	1,613	19,072	11.82	14
15	Cook Helpers/Assistants	730	730	5,626	7.71	15
16	Dishwashers					16
17	Maintenance Workers	505	678	5,909	8.72	17
18	Housekeepers	3,014	3,014	22,844	7.58	18
19	Laundry	1,825	1,825	14,065	7.71	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,978	2,008	15,970	7.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	8,751	9,541	75,003	7.86	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,361	21,354	\$ 173,484 *	\$ 8.12	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 1,905	1-3	35
36	Medical Director		2,100	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		12,927	10-3	38
39	Pharmacist Consultant		209	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant		8,651	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		5,525	10-3	43
44	Activity Consultant				44
45	Social Service Consultant		3,850	12-3	45
46	Other(specify) <u>QMRP/RSD</u>		53,050	10-3	46
47	<u>Psychologist</u>		2,473	10-3	47
48	<u>Dentist</u>		1,021	10-3	48
49	TOTAL (lines 35 - 48)		\$ 91,711		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number South Haven Home

# 0035253

Report Period Beginning: 10/1/01

**Ending: 09/30/02**

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
None			\$	Workers' Compensation Insurance		\$ 5,955	IDPH License Fee	\$
				Unemployment Compensation Insurance		2,306	Advertising: Employee Recruitment	457
				FICA Taxes		13,271	Health Care Worker Background Check (Indicate # of checks performed 17 )	208
				Employee Health Insurance		4,880	Dues & Subscriptions	1,076
				Employee Meals		4,704	Contributions	0
				Illinois Municipal Retirement Fund (IMRF)*			Schedule VIII Allocation	1,323
				Other		41	Less: Contributions	0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	Schedule VIII Allocation		25,285	Less: Public Relations Expense	(
B. Administrative - Other							Non-allowable advertising	(
Description			Amount				Yellow page advertising	(
Consulting			\$ 53,040				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,064
				TOTAL (agree to Schedule V, line 22, col.8)	\$	56,442		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 53,040	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount	None		\$	Out-of-State Travel	\$
Martin, Hood, Friese & Assoc.	Accounting		1,571					
Thomas, Mamer & Haughey	Legal		209				In-State Travel	
Health Services Consultants	Accounting		7,768				Schedule VIII Allocation	2,408
Health Services Consultants	Computer Consulting		1,655					
							Seminar Expense	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 11,203	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,408

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Haven Home

STATE OF ILLINOIS

# 0035253

Report Period Beginning:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA - \$819
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 25,781  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation. \_\_\_\_\_

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,704 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? Attached  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? None  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? None
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.